Testimony of Maritza Rosado to the State of Connecticut Appropriations Committee
Wednesday, March 9, 2011
Concerning Governor's Bill No. 1013, Section 13(b)
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Toni Nathaniel Harp, Co-Chair, Toni E. Walker, Co-Chair, Edith G. Prague, Vice-Chair, Catherine F. Abercrombie, Vice Chair, Genga J. Henry, Vice Chair, Patricia Billie Miller, Vice Chair and members of the Appropriations Committee:

INTRODUCTION

I would like to thank the members of the Appropriations Committee for the opportunity to submit a written testimony in support for sustaining funding for medical interpreters. I am opposed to the bill concerning the Elimination of Funding for Medical Interpreter Services under Medicaid as Proposed by Section 13(b) of Governor's Bill No. 1013.

My name is Maritza Rosado; I am resident of West Haven, and work as the Director of the Medical Interpreter program for Eastern Area Health Education Center (AHEC), Inc. Eastern AHEC is one of the four regional centers within the CT AHEC Program whose office is located at UConn Health Center. Eastern AHEC is a non-profit 5013(c) organization whose purpose is to engage in public and private partnerships that address health disparities in Connecticut. This is accomplished through supporting direct service providers and providing health professionals training and development programs, with the goal of increasing access to high quality care for underserved populations.

Much of my work is dedicated to the promotion of eliminating health disparities among limited or non-English speaking persons by participating in local and national efforts. Currently, I serve as the State Representative for the International Medical Interpreter Association (IMIA), a US-based international organization committed to the advancement of professional medical interpreters as the best practice for achieving equitable language access to health care for linguistically diverse patients. As the state representative, my goal is to ensure that medical interpreters statewide are abreast in this vast field in the state. In the state, I am actively involved with a statewide initiative, the Connecticut Multicultural Health Partnership (CMHP), as Co-Chair of the Language Access Services. The primary goal of the Language Access Services committee is to ensure that for people who do not speak English language is not a barrier to the receipt of appropriate health care and health education. Our committee believes that health care professionals and institutions should provide interpretation and language services to Limited or non-English speaking persons.

RELEVANCE OF NEED

Racial, ethnic and cultural disparities exist in all aspects of society, but nowhere are they more clearly documented than in health care[1]. Advances in medical science over the last century have led to substantial improvements in the nation's health. These advances, however, mask the fact that minorities often fare worse than whites on a variety of health indicators including mortality, morbidity, and many of the underlying causes of disease; and the impact of these disparities will become even more pronounced as the nation becomes more diverse. [2] The U. S. Census Bureau projects that by the year 2030 minorities will make up nearly 40 percent of the total population.[3] Additionally, more than 46 million people in the United States do not speak English as their primary language, and more than 21 million speak English with limited proficiency.[4] Over half of all foreign-born in the U.S. today have come from Latin American countries and speak Spanish.

An LEP individual is a person "who does not speak English as their primary language and has a limited ability to read, speak, write, or understand English.

Source: *U.S. Office of Civil Rights. Frequently Asked Questions about LEP. 2002.*

While ethnic diversity in the U.S. represents a major asset, it poses significant challenges in health care. Health care providers are recognizing the challenge of caring for patients from diverse linguistic and cultural backgrounds. Culture and the language and idioms specific to that culture can be powerful forces shaping individuals' perceptions of their world and themselves. Language, in particular, can stand as a barrier to interactions among people of different ethnic

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and cultural backgrounds, not only because of the obvious issues of interpretability, but also because language circumscribes the cognitive choices an individual has to define and interpret life experiences[5]. Language has been described as medicine's most essential technology; a principle instrument for conducting its work.[6]

As Connecticut becomes increasingly diverse, hospital systems face an enormous challenge in providing quality health services to LEP populations. In addition, health care providers face growing challenges to ensure that LEP patients have adequate language assistance services, such as access to interpreters and written materials translated into their native language.[7] *Speaking Together: National Language Services Network*, a project funded by the Robert Wood Johnson Foundation, is helping 10 hospitals identify, test, and assess strategies to effectively provide language services to patients with limited English proficiency. "*Speaking Together* participants say involving the language services team in quality improvement is revolutionary."[8] In order to increase quality improvement standards and reduce medical errors, the critical elements of effective communication between health care providers and LEP patients must be taken into consideration.[9] According to Marsha Regenstein, Principal Investigator of *Speaking Together*, most hospitals know that many of their patients speak languages other than English but very few know the true demand of languages services in their institution and how well they are meeting that demand.

> *The numbers suggest that there is ample patient demand for languages services, and when interpreters are called, they respond quickly. Too often, we believe that interpretation with an assessed language provider isn't happening at all, and the doctor, nurse and patient are cobbling together a conversation. This is obviously not a good way to provide high-quality care.*

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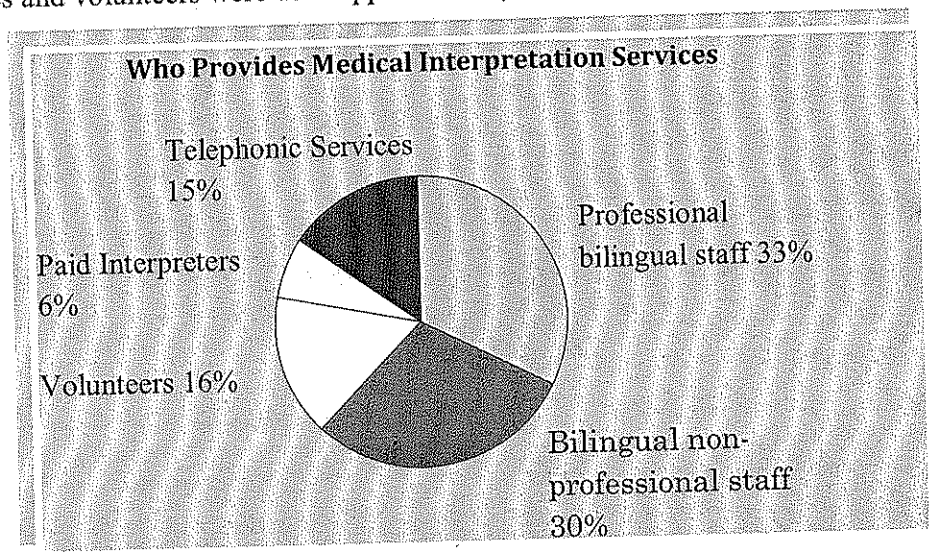
CONNECTICUT INITIATIVES AND FINDINGS

In 2004, the Connecticut AHEC Program conducted a Medical Interpretation Needs Assessment Survey of health care provider organizations, in collaboration with the Connecticut Hospital Association. Of the approximately 1,500 surveys distributed, 247 surveys were returned. The regional distribution of returned surveys approximated the population distribution. The low return rate, as explained by the Connecticut Hospital Association, reflected administrative concern of documenting inappropriate practices in providing medical interpretation services (e.g. using family members and under-aged children as interpreters).

The survey found that the majority of health care institutions relied on existing staff and patient relatives for medical interpretation. Most of the responding health care organizations (76%) spent less than $1,000 a year on interpretation services. With the exception of one hospital, respondents did not have a training program for staff members who serve as interpreters. More than half of the survey respondents reported that less than 5% of their professional staff is bilingual, indicating that existing staff who have medical training is insufficient to meet the interpretation needs of patient populations. Overall, medical interpretation was provided by bilingual professional staff 32% of the time and bilingual non-professional staff 30% of the time. Telephonic interpretations services and volunteers were used approximately 30% of the time.



Source: Connecticut AHEC Medical Interpreter Needs Assessment 2004

The medical interpreter needs assessment data suggested that the three most difficult types of interpretation services for health care organizations to provide are:

- **Adequate staff training in the use of medical interpretation services.**
- **Providing formal training to bilingual staff members in medical interpretation.**
- **Assessing language fluency in bilingual staff members who provide medical interpretation services.**

LANGUAGE NEEDS AND SERVICES OF LOCAL HEALTH DISTRICTS AND COMMUNITY HEALTH CENTERS PRESENTED BY THE CMHP LANGUAGE SERVICE COMMITTEE

Local Health Departments

Types of Languages Services Offered

Translations are the most common form of language service, with three-quarters of the LHDs providing educational materials, and 70% having signs and posters or forms written in a language other than English. The most common method of providing interpretation was through bilingual staff (30%), followed by volunteer interpreters (22%).

Types of Languages Services Offered by HDs (n=32)

	Offer	Planning	Do not offer
Translated educational materials	76%	9%	15%
Translated signs & posters	70%	6%	24%
Translated forms	52%	12%	36%
Bilingual staff	30%	3%	67%
Volunteer interpreters	22%	19%	59%
Media outlets	18%	3%	79%
Telephone language lines	18%	3%	81%
Communication Boards	6%	6%	88%
Paid interpreters	9%	6%	85%
Web-based information	6%	12%	82%

Survey Highlights

- The 33 respondents (hospitals and health care agencies) provide public health services to over 2 million Connecticut residents.
- Nearly one-third of the LHDs encountered people with LEP every week and, at the other end of the spectrum, one-third had encounters less than once a month.
- Spanish was the most common language encountered, with Chinese being second.
- Slightly less than half of the LHDs conducted an assessment of the size of LEP population in their community.
- The cost of providing language services was the highest ranking barrier to address the needs of LEP community.
- Other challenges included limited availability of interpreters and limited availability of translated materials for some languages.

Community Health Centers
Types of Language Services Offered

Face-to-face independent or contractual interpreters (both professional and volunteer) were rarely used for Spanish or other languages. Telephonic interpretation was used by all CHCs for Spanish speaking patients and by 89% for patients who speak languages other than English or Spanish. Signage in Spanish was used by two-thirds of the CHCs and signage in other languages buy one-third. Twenty-two percent have Spanish language health education programs, but none of the Centers offered classes in other languages. Social networks or bulletin boards are utilized to communicate with patients in Spanish but not to communicate in other languages.

Types of Languages Services Offered by CHCs (n=9)	Spanish	Other languages
In-person interpretation		
Bilingual clinical staff	100%	67%
Bilingual non-clinical staff	100%	44%
Bilingual staff interpreters	78%	22%
Family members	89%	100%
Independent interpreter	0%	0%
Commercial service	11%	0%
Volunteers	0%	0%
Technological interpretation		
Telephone interpretation	100%	89%
Video-Conferencing	0%	0%
Other services		
Signage	67%	33%
Health education information	22%	0%

Survey Summary

Community Health Centers and Local Health Departments do provide many types language services for their clients, yet it is a challenge for them to provide language services for everyone because of the large number of people who do not speak English and the many different languages that they speak. This is evident with the high number of LHD that do not have access to interpreter and translation services and CHCs that continue to use family members to interpret. These providers acknowledge that more language services are needed but lack of funding is a significant barrier to doing more.

CONCLUSION

There is a magnitude of medical literature demonstrating that the absence of medical interpretation has a harmful effect on both access to health care and delivery of high quality health care services for patients with limited English proficiency. Thus, this lack contributes to poorer health outcomes for those patients, less adequate treatment for chronic medical conditions and the necessity for more costly acute medical services. There is a need for medical interpretation services for Connecticut's limited and non-English proficient citizens - in order to assure proper care, better health outcomes, and, ultimately promote patient safety. Nevertheless, Governor's Bill No. 1013 proposes to delay funding of these services for Medicaid beneficiaries. This proposal is restrictive, and will not save money because delivery of medical care when provider and patient cannot communicate is inefficient and the federal government will pay for part of the costs through the Medicaid match.

On behalf of myself and Eastern AHEC, Inc, I request that as members of the Appropriation Committee each of you respectively support funding for medical interpreter services. The proposed governor's bill concerning the Elimination of Funding for Medical Interpreter Services under Medicaid as Proposed by Section 13(b) of Governor's Bill No. 1013 is injudicious approach towards addressing the current budget crisis.

Respectively submitted,

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Eastern AHEC, Inc
Director, Medical Interpreter Training Program
IMIA Connecticut State Representative
Co-Chair, Language Access Services Committee, CMHP
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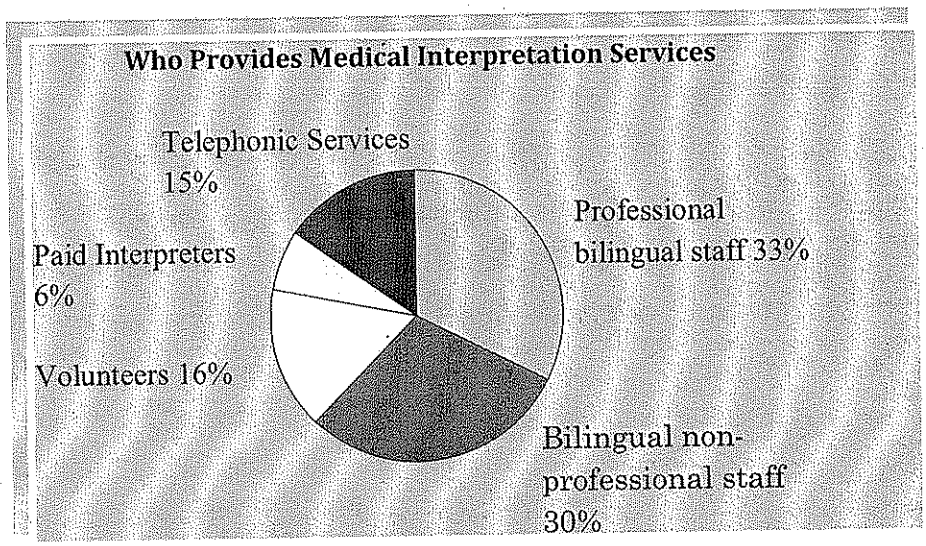

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